Claims

1. A method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising the steps of:

selecting an activity code from a predetermined activity code set including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection;

assigning said selected activity code to rejected claim data associated with said received notification;

scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected activity code; and

preparing said corrected claim data for submission to a payer organization for payment.

2. A method according to claim 1, wherein

said predetermined activity code set is different from a set of codes identifying a nonpayment reason associated with said rejected claim data comprising at least one of, (a) a rejection reason, (b) a rejection activity code representing the rejection reason, (c) a denial reason, and (d) a denial activity code representing the denial reason.

3. A method according to claim 1, including the step of

receiving a nonpayment code comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data, and

said selecting step comprises interpreting said received nonpayment code to determine, from said predetermined activity code set, an activity code compatible with said nonpayment code.

4. A method according to claim 1, including the steps of

receiving a nonpayment code comprising at least one of, (a) a rejection code and (b) a denial code associated with said rejected claim data, and

interpreting said received nonpayment code,

translating said interpreted received nonpayment code to a code compatible with a predetermined nonpayment code set employed by an organization performing said processing claim data for reimbursement of provision of healthcare to said patient.

5. A method according to claim 4, wherein

said predetermined nonpayment code set includes fewer codes than a code set used to derive said received nonpayment code.

6. A method according to claim 1, including the step of

assigning a time and date identifier to rejected claim data associated with said received notification, said identifier indicating a time and date indicative of at least one of, (a) a time and date associated with scheduling a task comprising performing processing concerning said rejected claim data, (b) a time and date associated with processing said received notification of claim denial or rejection, (c) a time and date associated with receiving notification of claim denial or rejection and (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data.

7. A method according to claim 1, including the steps of

assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data and

initiating generation of a message alerting a user to at least one of, (a) said period is due to expire at said time and date and (b) said period has expired.

8. A method according to claim 1, wherein

said method is used to provide corrected claim data for a plurality of rejected claims in response to a corresponding plurality of received notifications of claim denial or rejection and including the step of

collating data concerning said rejected claims by at least one of, (a) payer organization associated with said notification and (b) reason for claim rejection or denial derived from said notification.

9. A method according to claim 1, wherein

said method is used to provide corrected claim data for a plurality of rejected claims in response to a corresponding plurality of received notifications and including the step of

collating rejected claim data by at least one of, (a) payer organization associated with said notification, (b) assigned activity code and (c) type of request for information indicated in a corresponding notification.

10. A method according to claim 1, including the step of

acquiring statistics concerning at least one of, (a) type and frequency of claim rejections, (b) type and frequency of claim denials, (c) data identifying success rate of first time claims submissions for an individual payer, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer, (e) data indicating a time duration expected for processing a non-paid claim until re-submission and (f) data identifying a proportion of non-recoverable claims for an individual payer.

11. A method according to claim 10, including the step of

employing said statistics to at least one of, (i) modify processing of said rejected claim data and (ii) create a statistical report for an individual payer.

12. A method according to claim 1, including the step of

determining from said notification whether said rejected claim data was denied or rejected and wherein

said selecting step comprises selecting a first activity code in response to a denial notification and a different second activity code in response to a rejection notification.

13. A method according to claim 1, wherein

said method steps are performed automatically and at least one of, (a) excluding manual intervention and (b) employing partial manual intervention by one or more healthcare workers.

14. A method for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising the steps of:

identifying a nonpayment code, associated with a predetermined nonpayment code set, from a received notification of claim nonpayment associated with particular claim data;

selecting an activity code from a predetermined activity code set including a plurality of codes identifying processing to be performed concerning non-paid claim data in response to said identified nonpayment reason;

assigning said selected activity code to said particular claim data associated with said received notification;

scheduling a task comprising performing processing concerning said particular claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected activity code; and

preparing said corrected claim data for submission to a payer organization for payment.

15. A method according to claim 14, wherein

said identified nonpayment code comprises at least one of, (i) a rejection code and (ii) a denial code associated with said particular claim data, and

said selecting step comprises interpreting said identified nonpayment code to determine, from said predetermined activity code set, an activity code compatible with said nonpayment code.

16. A method according to claim 14, wherein

said predetermined nonpayment code set is compatible with a HIPAA standard code set.

17. A system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising:

a workflow processor for,

selecting an activity code from a predetermined activity code set including a plurality of codes identifying processing to be performed concerning rejected claim data in response to a received notification of claim denial or rejection;

assigning said selected activity code to rejected claim data associated with said received notification;

scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (a) claim data supplemental to said rejected claim data and (b) amended rejected claim data, in response to said assigned selected activity code; and

an interface processor for preparing said corrected claim data for submission to a payer organization for payment.